



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

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Health Resources and Service Administration  
Department of Health and Human Services  
Attention: Ms. Andy Jordan  
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**Subject: Michigan Department of Community Health Comments on the Health Resources and Service Administration Proposed Rule for Designation of Medically Underserved Populations and Health Professional Shortage Areas**

**General Comments:**

The new criteria will affect the distribution of HPSA and MUA/P designated areas in Michigan. Federal estimates suggest that, although there will be a slightly different set of areas designated, the number of Michigan HPSAs designated under the new criteria will be no fewer than 81% of the current number. Similarly, 90% of the number of MUAs and MUPs currently designated will be designated under the new criteria. HRSA staff has indicated that these figures over-estimate the loss of designation number and population and that the percentages cited above are likely to be higher when local data is included in the analysis. Michigan Department of Community Health (MDCH) staff concur with these observations.

MDCH staff conducted an analysis of each Michigan county and the prospect for geographic HPSA designation under the new criteria. This analysis estimates that 8 of 11 current full-county geographic HPSAs in Michigan will remain full-county geographic HPSAs under the new criteria. Additionally, eight counties that do not currently have full-county geographic HPSAs will be eligible to have such designations under the new criteria. Although it would be a different set of designated areas, 16 counties could be full-county geographic designations under the new criteria.

A complete MDCH analysis of low-income population group designations is not possible with available data, but there is not evidence to suggest the results of this analysis will differ significantly from the federal analysis that 81% of the number of Michigan's current HPSAs will be designated under the new criteria. Crucial to this observation is the provision under the proposed rule that population group designations be evaluated as nearly as possible, to the population group itself in terms of both provider FTE and high need indicator variables.

Preliminary analysis of existing sub-county HPSA designations in Wayne County suggest that designations of this type (in high poverty areas with a high percentage minority population and elevated infant mortality/low birth-weight rates) should be impacted minimally by the new criteria. MDCH staff expects to maintain most currently designated HPSAs in Wayne County under the proposed criteria.

There will likely be a number of current designations that are not re-designated under the new criteria. However, there is the potential for new areas to be identified as meeting the criteria for designation that are not currently designated.

One of HRSA's stated goals in defining the new criteria was to develop a system that better identifies areas in need. The criteria described in the proposed rule, do appear to provide a more evidence-based approach to identifying areas with a need for primary care resources than do the existing criteria.

Overall, MDCH views the proposed rule as an improvement over the existing criteria for designating Health Professional Shortage Areas and Medically Underserved Populations. MDCH is supportive of the rationale behind the proposed rule and is generally supportive of the proposed methodology itself. Some areas of concern have been identified with the proposed rule as currently written, and these concerns are discussed below.

**Concerns Related to the Proposed Rule:**

*Concern:* Although not a criticism of the criteria described in the proposed rule, of considerable concern is the absence of information on how the new system of designations will be interpreted by federal programs utilizing HPSA and MUA/P designations. Given the differences described in the proposed rule from the current system of designations (the 2 tier system, differences in scoring, safety-net facility designations, etc.) it is not entirely clear how programs including the National Health Service Corps, grant funding for Section 330 Community Health Centers, Rural Health Clinics Certification, and the CMS 10% Medicare Bonus Payment will adjust their programmatic interpretations of designation status to accommodate the proposed rule.

For example, there may be a conflict under the proposed rule if an area is eligible for both a tier 1 population group designation and a tier 2 geographic designation. If tier 1 population group designations are priorities over tier 2 geographic designations for some provider recruitment programs, but tier 2 geographic designations provide access to the Medicare incentive payment where population group designations do not, it is not clear what designation is more beneficial to the area under consideration.

*Response:* MDCH requests that programs utilizing HPSA and MUA/P designations as criteria make information available on their programmatic interpretations of the proposed rule. The opportunity to comment on such programmatic interpretations before their implementation would be appreciated.

With respect to the potential conflict between tier 2 geographic and tier 1 population group designations, a possible solution is to allow designation (for those areas that meet the requirements for both designations) as both a tier 2 geographic and a tier 1 population group designation. A dual designation of this type alleviates the potential for conflict, and does not seem out of the bounds of the current designation system in which facility HPSAs are often dually designated within geographic areas or population group designations.

*Concern:* MDCH supports the availability of a safety-net facility designation as described in the proposed rule, however the proposed regulations lack clarity in the requirements for safety-net facility designation and do not contain a provision for the scoring of such designations.

*Response:* MDCH recommends that the final rule contain a clear statement on the requirements for safety-net facility designation. In particular, the rule should state whether designation requires 10% sliding fee scale/no fee patients **and** or **or** a combined 40%, 30%, or 20% Medicaid and sliding fee scale/no fee patients based on metropolitan, non-metropolitan, or frontier status respectively.

Additionally, MDCH recommends that a system for scoring safety-net facility designations be added to the final rule.

*Concern:* MDCH supports the idea of federal designation analysis prior to state involvement, however it appears that under the proposed rule, states currently utilizing provider surveys for shortage designation activity and states with large numbers of population group designations will be more heavily impacted by workload requirements than states that do not utilize provider surveying or do not have high numbers of population group designations. States currently utilizing provider surveys will likely see less benefit to the automatic Shortage Designation Branch review of designations (using national data) than states that do not survey. Similarly, the Shortage Designation Branch review will only determine eligibility for geographic designations and will likely leave many population group designations for state level analysis. Further enhancing the disparity in impact is the addition of physician assistants, nurse practitioners, and certified nurse midwives to provider counts. Although MDCH supports a more complete analysis of the primary care workforce, the addition of more providers to the population of providers being surveyed will likely increase the number of surveys needing to be performed.

*Response:* MDCH recommends that the Shortage Designation Branch provide an estimate of low-income population group provider counts (as was done for the impact analysis summarized in the *Federal Register*) to allow for an automatic review with national data of population group designations.

Additionally, MDCH recommends that the Shortage Designation Branch provide a method to apply physician survey data regarding service provision to population groups (i.e. the low-income population) to physician assistants, nurse practitioners, and certified nurse midwives so that surveys aren't necessarily required for a larger provider group than is required under the current criteria. Alternatively, a methodology for designating primary medical care designations requiring only physician information (similar to the mental health care HPSA regulations separating psychiatrists from other core mental health care providers) would address this issue.

*Concern:* Further clarification is needed on what data sources for population figures, high need indicator values, and non-physician clinicians are available and acceptable for use under the proposed criteria. The addition of the population adjustment for differences in utilization by age and gender is welcomed by MDCH, but it is not clear that data (especially for population groups) is necessarily available to assist in making these adjustments outside of total population figures. Similarly, it is not clear that complete national data sources exist for non-physician clinician data. Given the lack of national data for the non-physician clinicians, the initial federal review and determination of designation status based on national provider counts may be biased against those areas with relatively more physicians and fewer mid-level providers, solely based on completeness of available data for different provider types.

*Response:* MDCH recommends that HRSA provide a clear description of data sources and methods for accessing those data sources in the final rule. Where population data may not be available at a specificity that will allow adjustment based on utilization rates, HRSA should make available to states an approved mechanism for estimating these adjustments.

MDCH recommends that HRSA identify an acceptable source for non-physician clinician data or make investments to develop such a source if none exists.

*Concern:* MDCH appreciates the purpose of the tier 2 designation and the expansion of the provider types excluded from tier 2 provider counts (SLRP and FQHC providers in addition to NHSC and J-1 providers that are currently excluded from HPSA designation provider counts). However, it has come to the Department's attention that Rural Health Clinic and National Interest Waiver providers are notable exceptions from this list of provider exclusions and that their presence in shortage designated areas (as a result of the designation) can significantly impact area provider counts.

*Response:* Following the logic that federally sponsored providers such as J-1 and community health center providers are in an area largely because of a shortage designation, and that they should be excluded from tier 2 counts because they have been brought to an area based on that designation: MDCH concludes it is reasonable to exclude from tier 2 designation provider counts those providers practicing at Certified Rural Health Clinics and those practicing with a National Interest Waiver.

For additional information or clarification regarding these comments, please contact Ian A. Horste, MDCH Primary Care Workforce Analyst, at [HorsteI@michigan.gov](mailto:HorsteI@michigan.gov) or (517) 241-9947.